General Assembly

Substitute Bill No. 6367

January Session, 2013

HB06367APP 042313

AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET RECOMMENDATIONS FOR HUMAN SERVICES PROGRAMS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subsection (b) of section 10-295 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2013*):

(b) The Commissioner of Rehabilitation Services shall expend funds for the services made available pursuant to subsection (a) of this section from the educational aid for blind and visually handicapped children account in accordance with the provisions of this subsection. The expense of such services shall be paid by the state in an amount not to exceed six thousand four hundred dollars in any one fiscal year for each child who is blind or visually impaired. The Commissioner of Rehabilitation Services may adopt, in accordance with the provisions of chapter 54, such regulations as the commissioner deems necessary to carry out the purpose and intent of this subsection.

(1) The Commissioner of Rehabilitation Services shall provide, upon written request from any interested school district, the services of teachers of the visually impaired, based on the levels established in the individualized education or service plan. The Commissioner of Rehabilitation Services shall also make available resources, including,

but not limited to, the Braille and large print library, to all teachers of public and nonpublic school children. The commissioner may also provide vision-related professional development and training to all school districts and cover the actual cost for paraprofessionals from school districts to participate in agency-sponsored Braille training programs. The commissioner shall utilize education consultant positions, funded by moneys appropriated from the General Fund, to supplement new staffing that will be made available through the educational aid for the blind and visually handicapped children account, which shall be governed by formal written policies established by the commissioner.

(2) The Commissioner of Rehabilitation Services shall use funds appropriated to said account, first to provide specialized books, materials, equipment, supplies, adaptive technology services and devices, specialist examinations and aids, preschool programs and vision-related independent living services, excluding primary educational placement, for eligible children without regard to a per child statutory maximum.

(3) The Commissioner of Rehabilitation Services may, within available appropriations, employ certified teachers of the visually impaired in sufficient numbers to meet the requests for services received from school districts. In responding to such requests, the commissioner shall utilize a formula for determining the number of teachers needed to serve the school districts, crediting six points for each Braille-learning child and one point for each other child, with one full-time certified teacher of the visually impaired assigned for every twenty-five points credited. The commissioner shall exercise due diligence to employ the needed number of certified teachers of the visually impaired, but shall not be liable for lack of resources. Funds appropriated to said account may also be utilized to employ rehabilitation teachers, rehabilitation technologists and orientation and mobility teachers in numbers sufficient to provide compensatory skills evaluations and training to blind and visually impaired children. In

addition, up to five per cent of such appropriation may also be utilized to employ special assistants to the blind and other support staff necessary to ensure the efficient operation of service delivery. Not later than October first of each year, the Commissioner of Rehabilitation Services shall determine the number of teachers needed based on the formula provided in this subdivision. Based on such determination, the Commissioner of Rehabilitation Services shall estimate the funding needed to pay such teachers' salaries, benefits and related expenses.

(4) In any fiscal year, when funds appropriated to cover the combined costs associated with providing the services set forth in subdivisions (2) and (3) of this subsection are projected to be insufficient, the Commissioner of Rehabilitation Services **[**shall be authorized to**]** may collect revenue from all school districts that have requested such services on a per student pro rata basis, in the sums necessary to cover the projected portion of these services for which there are insufficient appropriations.

[(5) Remaining funds in said account, not expended to fund the services set forth in subdivisions (2) and (3) of this subsection, shall be used to cover on a pro rata basis, the actual cost with benefits of retaining a teacher of the visually impaired, directly hired or contracted by the school districts which opt to not seek such services from the Commissioner of Rehabilitation Services, provided such teacher has participated in not less than five hours of professional development training on vision impairment or blindness during the school year. Reimbursement shall occur at the completion of the school year, using the caseload formula denoted in subdivision (3) of this section, with twenty-five points allowed for the maximum reimbursable amount as established by the commissioner annually.

(6) Remaining funds in such account, not expended to fund the services set forth in subdivisions (2), (3) and (5) of this subsection, shall be distributed to the school districts on a pro rata formula basis with a two-to-one credit ratio for Braille-learning students to non-Braille-learning students in the school district based upon the annual child

count data provided pursuant to subdivision (1) of this subsection, provided the school district submits an annual progress report in a format prescribed by the commissioner for each eligible child.**]**

Sec. 2. Section 17b-607 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2013*):

(a) The Commissioner of **[**Social**]** Rehabilitation Services is authorized to establish and administer a fund to be known as the Assistive Technology Revolving Fund. Said fund shall be used by said commissioner to make loans to persons with disabilities, senior citizens or the family members of persons with disabilities and senior citizens for the purchase of assistive technology and adaptive equipment and services. Each such loan shall be made for a term of not more than **[**five**]** ten years. Any loans made under this section shall bear interest at a **[**rate to be determined in accordance with subsection (t) of section 3-20**]** fixed rate determined by the commissioner, not to exceed six per cent. Said commissioner is authorized to expend any funds necessary for the reasonable direct expenses relating to the administration of said fund. Said commissioner shall adopt regulations, in accordance with the provisions of chapter 54, to implement the purposes of this section.

(b) The State Bond Commission shall have power from time to time to authorize the issuance of bonds of the state in one or more series in accordance with section 3-20 and in a principal amount necessary to carry out the purposes of this section, but not in excess of an aggregate amount of one million dollars. All of said bonds shall be payable at such place or places as may be determined by the Treasurer pursuant to section 3-19 and shall bear such date or dates, mature at such time or times, not exceeding five years from their respective dates, bear interest at such rate or different or varying rates and payable at such time or times, be in such denominations, be in such form with or without interest coupons attached, carry such registration and transfer privileges, be payable in such medium of payment and be subject to such terms of redemption with or without premium as, irrespective of

the provisions of said section 3-20, may be provided by the authorization of the State Bond Commission or fixed in accordance therewith. The proceeds of the sale of such bonds shall be deposited in the Assistive Technology Revolving Fund created by this section. Such bonds shall be general obligations of the state and the full faith and credit of the state of Connecticut are pledged for the payment of the principal of and interest on such bonds as the same become due. Accordingly, and as part of the contract of the state with the holders of such bonds, appropriation of all amounts necessary for punctual payment of such principal and interest is hereby made and the Treasurer shall pay such principal and interest as the same become due. Net earnings on investments or reinvestments of proceeds, accrued interest and premiums on the issuance of such bonds, after payment therefrom of expenses incurred by the Treasurer or State Bond Commission in connection with their issuance, shall be deposited in the General Fund of the state.

(c) There is established, within the Department of Rehabilitation Services, the Connecticut Tech Act Project. In accordance with the provisions of 29 USC 3001, the project may provide assistive technology evaluation and training services upon the request of any person or any public or private entity, to the extent persons who provide assistive technology services are available. The project may charge a fee to any person or entity receiving such assistive technology evaluation and training services to reimburse the department for its costs. The Commissioner of Rehabilitation Services shall establish fees at reasonable rates that will cover the department's direct and indirect costs.

Sec. 3. Subdivision (4) of subsection (f) of section 17b-340 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2013*):

(4) For the fiscal year ending June 30, 1992, (A) no facility shall receive a rate that is less than the rate it received for the rate year ending June 30, 1991; (B) no facility whose rate, if determined pursuant

to this subsection, would exceed one hundred twenty per cent of the state-wide median rate, as determined pursuant to this subsection, shall receive a rate which is five and one-half per cent more than the rate it received for the rate year ending June 30, 1991; and (C) no facility whose rate, if determined pursuant to this subsection, would be less than one hundred twenty per cent of the state-wide median rate, as determined pursuant to this subsection, shall receive a rate which is six and one-half per cent more than the rate it received for the rate year ending June 30, 1991. For the fiscal year ending June 30, 1993, no facility shall receive a rate that is less than the rate it received for the rate year ending June 30, 1992, or six per cent more than the rate it received for the rate year ending June 30, 1992. For the fiscal year ending June 30, 1994, no facility shall receive a rate that is less than the rate it received for the rate year ending June 30, 1993, or six per cent more than the rate it received for the rate year ending June 30, 1993. For the fiscal year ending June 30, 1995, no facility shall receive a rate that is more than five per cent less than the rate it received for the rate year ending June 30, 1994, or six per cent more than the rate it received for the rate year ending June 30, 1994. For the fiscal years ending June 30, 1996, and June 30, 1997, no facility shall receive a rate that is more than three per cent more than the rate it received for the prior rate year. For the fiscal year ending June 30, 1998, a facility shall receive a rate increase that is not more than two per cent more than the rate that the facility received in the prior year. For the fiscal year ending June 30, 1999, a facility shall receive a rate increase that is not more than three per cent more than the rate that the facility received in the prior year and that is not less than one per cent more than the rate that the facility received in the prior year, exclusive of rate increases associated with a wage, benefit and staffing enhancement rate adjustment added for the period from April 1, 1999, to June 30, 1999, inclusive. For the fiscal year ending June 30, 2000, each facility, except a facility with an interim rate or replaced interim rate for the fiscal year ending June 30, 1999, and a facility having a certificate of need or other agreement specifying rate adjustments for the fiscal year ending June 30, 2000, shall receive a rate increase equal to one per cent applied to the rate the

facility received for the fiscal year ending June 30, 1999, exclusive of the facility's wage, benefit and staffing enhancement rate adjustment. For the fiscal year ending June 30, 2000, no facility with an interim rate, replaced interim rate or scheduled rate adjustment specified in a certificate of need or other agreement for the fiscal year ending June 30, 2000, shall receive a rate increase that is more than one per cent more than the rate the facility received in the fiscal year ending June 30, 1999. For the fiscal year ending June 30, 2001, each facility, except a facility with an interim rate or replaced interim rate for the fiscal year ending June 30, 2000, and a facility having a certificate of need or other agreement specifying rate adjustments for the fiscal year ending June 30, 2001, shall receive a rate increase equal to two per cent applied to the rate the facility received for the fiscal year ending June 30, 2000, subject to verification of wage enhancement adjustments pursuant to subdivision (14) of this subsection. For the fiscal year ending June 30, 2001, no facility with an interim rate, replaced interim rate or scheduled rate adjustment specified in a certificate of need or other agreement for the fiscal year ending June 30, 2001, shall receive a rate increase that is more than two per cent more than the rate the facility received for the fiscal year ending June 30, 2000. For the fiscal year ending June 30, 2002, each facility shall receive a rate that is two and one-half per cent more than the rate the facility received in the prior fiscal year. For the fiscal year ending June 30, 2003, each facility shall receive a rate that is two per cent more than the rate the facility received in the prior fiscal year, except that such increase shall be effective January 1, 2003, and such facility rate in effect for the fiscal year ending June 30, 2002, shall be paid for services provided until December 31, 2002, except any facility that would have been issued a lower rate effective July 1, 2002, than for the fiscal year ending June 30, 2002, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2002, and have such rate increased two per cent effective June 1, 2003. For the fiscal year ending June 30, 2004, rates in effect for the period ending June 30, 2003, shall remain in effect, except any facility that would have been issued a lower rate effective July 1, 2003, than for the fiscal year ending June 30,

2003, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2003. For the fiscal year ending June 30, 2005, rates in effect for the period ending June 30, 2004, shall remain in effect until December 31, 2004, except any facility that would have been issued a lower rate effective July 1, 2004, than for the fiscal year ending June 30, 2004, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2004. Effective January 1, 2005, each facility shall receive a rate that is one per cent greater than the rate in effect December 31, 2004. Effective upon receipt of all the necessary federal approvals to secure federal financial participation matching funds associated with the rate increase provided in this subdivision, but in no event earlier than July 1, 2005, and provided the user fee imposed under section 17b-320 is required to be collected, for the fiscal year ending June 30, 2006, the department shall compute the rate for each facility based upon its 2003 cost report filing or a subsequent cost year filing for facilities having an interim rate for the period ending June 30, 2005, as provided under section 17-311-55 of the regulations of Connecticut state agencies. For each facility not having an interim rate for the period ending June 30, 2005, the rate for the period ending June 30, 2006, shall be determined beginning with the higher of the computed rate based upon its 2003 cost report filing or the rate in effect for the period ending June 30, 2005. Such rate shall then be increased by eleven dollars and eighty cents per day except that in no event shall the rate for the period ending June 30, 2006, be thirty-two dollars more than the rate in effect for the period ending June 30, 2005, and for any facility with a rate below one hundred ninety-five dollars per day for the period ending June 30, 2005, such rate for the period ending June 30, 2006, shall not be greater than two hundred seventeen dollars and forty-three cents per day and for any facility with a rate equal to or greater than one hundred ninety-five dollars per day for the period ending June 30, 2005, such rate for the period ending June 30, 2006, shall not exceed the rate in effect for the period ending June 30, 2005, increased by eleven and one-half per cent. For each facility with an interim rate for the period ending June 30, 2005, the interim

replacement rate for the period ending June 30, 2006, shall not exceed the rate in effect for the period ending June 30, 2005, increased by eleven dollars and eighty cents per day plus the per day cost of the user fee payments made pursuant to section 17b-320 divided by annual resident service days, except for any facility with an interim rate below one hundred ninety-five dollars per day for the period ending June 30, 2005, the interim replacement rate for the period ending June 30, 2006, shall not be greater than two hundred seventeen dollars and forty-three cents per day and for any facility with an interim rate equal to or greater than one hundred ninety-five dollars per day for the period ending June 30, 2005, the interim replacement rate for the period ending June 30, 2006, shall not exceed the rate in effect for the period ending June 30, 2005, increased by eleven and one-half per cent. Such July 1, 2005, rate adjustments shall remain in effect unless (i) the federal financial participation matching funds associated with the rate increase are no longer available; or (ii) the user fee created pursuant to section 17b-320 is not in effect. For the fiscal year ending June 30, 2007, each facility shall receive a rate that is three per cent greater than the rate in effect for the period ending June 30, 2006, except any facility that would have been issued a lower rate effective July 1, 2006, than for the rate period ending June 30, 2006, due to interim rate status or agreement with the department, shall be issued such lower rate effective July 1, 2006. For the fiscal year ending June 30, 2008, each facility shall receive a rate that is two and nine-tenths per cent greater than the rate in effect for the period ending June 30, 2007, except any facility that would have been issued a lower rate effective July 1, 2007, than for the rate period ending June 30, 2007, due to interim rate status or agreement with the department, shall be issued such lower rate effective July 1, 2007. For the fiscal year ending June 30, 2009, rates in effect for the period ending June 30, 2008, shall remain in effect until June 30, 2009, except any facility that would have been issued a lower rate for the fiscal year ending June 30, 2009, due to interim rate status or agreement with the department shall be issued such lower rate. For the fiscal years ending June 30, 2010, and June 30, 2011, rates in effect for the period ending June 30, 2009, shall remain in

effect until June 30, 2011, except any facility that would have been issued a lower rate for the fiscal year ending June 30, 2010, or the fiscal year ending June 30, 2011, due to interim rate status or agreement with the department, shall be issued such lower rate. For the fiscal years ending June 30, 2012, and June 30, 2013, rates in effect for the period ending June 30, 2011, shall remain in effect until June 30, 2013, except any facility that would have been issued a lower rate for the fiscal year ending June 30, 2012, or the fiscal year ending June 30, 2013, due to interim rate status or agreement with the department, shall be issued such lower rate. For the fiscal years ending June 30, 2014, and June 30, 2015, rates shall not exceed those in effect for the period ending June 30, 2013. Any facility that would have been issued a lower rate for the fiscal year ending June 30, 2014, or the fiscal year ending June 30, 2015, due to rebasing, available appropriations, interim rate status or agreement with the department, shall be issued such lower rate. The Commissioner of Social Services shall add fair rent increases to any other rate increases established pursuant to this subdivision for a facility which has undergone a material change in circumstances related to fair rent, except for the fiscal years ending June 30, 2010, June 30, 2011, and June 30, 2012, such fair rent increases shall only be provided to facilities with an approved certificate of need pursuant to section 17b-352, 17b-353, 17b-354 or 17b-355. For the fiscal year ending June 30, 2013, the commissioner may, within available appropriations, provide pro rata fair rent increases for facilities which have undergone a material change in circumstances related to fair rent additions placed in service in cost report years ending September 30, 2008, to September 30, 2011, inclusive, and not otherwise included in rates issued. For the fiscal year ending June 30, 2013, the commissioner shall add fair rent increases associated with an approved certificate of need pursuant to section 17b-352, 17b-353, 17b-354 or 17b-355. Interim rates may take into account reasonable costs incurred by a facility, including wages and benefits. Notwithstanding the provisions of this section, the Commissioner of Social Services may, **[**within**]** subject to available appropriations, increase or decrease rates issued to licensed chronic and convalescent nursing homes and licensed rest homes with nursing

supervision.

Sec. 4. Subdivision (1) of subsection (h) of section 17b-340 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2013*):

(h) (1) For the fiscal year ending June 30, 1993, any residential care home with an operating cost component of its rate in excess of one hundred thirty per cent of the median of operating cost components of rates in effect January 1, 1992, shall not receive an operating cost component increase. For the fiscal year ending June 30, 1993, any residential care home with an operating cost component of its rate that is less than one hundred thirty per cent of the median of operating cost components of rates in effect January 1, 1992, shall have an allowance for real wage growth equal to sixty-five per cent of the increase determined in accordance with subsection (q) of section 17-311-52 of the regulations of Connecticut state agencies, provided such operating cost component shall not exceed one hundred thirty per cent of the median of operating cost components in effect January 1, 1992. Beginning with the fiscal year ending June 30, 1993, for the purpose of determining allowable fair rent, a residential care home with allowable fair rent less than the twenty-fifth percentile of the state-wide allowable fair rent shall be reimbursed as having allowable fair rent equal to the twenty-fifth percentile of the state-wide allowable fair rent. Beginning with the fiscal year ending June 30, 1997, a residential care home with allowable fair rent less than three dollars and ten cents per day shall be reimbursed as having allowable fair rent equal to three dollars and ten cents per day. Property additions placed in service during the cost year ending September 30, 1996, or any succeeding cost year shall receive a fair rent allowance for such additions as an addition to three dollars and ten cents per day if the fair rent for the facility for property placed in service prior to September 30, 1995, is less than or equal to three dollars and ten cents per day. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the allowance for real wage growth, as determined in

accordance with subsection (q) of section 17-311-52 of the regulations of Connecticut state agencies, shall not be applied. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the inflation adjustment made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies shall not be applied to real property costs. Beginning with the fiscal year ending June 30, 1997, minimum allowable patient days for rate computation purposes for a residential care home with twenty-five beds or less shall be eighty-five per cent of licensed capacity. Beginning with the fiscal year ending June 30, 2002, for the purposes of determining the allowable salary of an administrator of a residential care home with sixty beds or less the department shall revise the allowable base salary to thirty-seven thousand dollars to be annually inflated thereafter in accordance with section 17-311-52 of the regulations of Connecticut state agencies. The rates for the fiscal year ending June 30, 2002, shall be based upon the increased allowable salary of an administrator, regardless of whether such amount was expended in the 2000 cost report period upon which the rates are based. Beginning with the fiscal year ending June 30, 2000, and until the fiscal year ending June 30, 2009, inclusive, the inflation adjustment for rates made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies shall be increased by two per cent, and beginning with the fiscal year ending June 30, 2002, the inflation adjustment for rates made in accordance with subsection (c) of said section shall be increased by one per cent. Beginning with the fiscal year ending June 30, 1999, for the purpose of determining the allowable salary of a related party, the department shall revise the maximum salary to twenty-seven thousand eight hundred fifty-six dollars to be annually inflated thereafter in accordance with section 17-311-52 of the regulations of Connecticut state agencies and beginning with the fiscal year ending June 30, 2001, such allowable salary shall be computed on an hourly basis and the maximum number of hours allowed for a related party other than the proprietor shall be increased from forty hours to forty-eight hours per work week. For the fiscal year ending June 30, 2005, each facility shall receive a rate that is two and one-quarter per cent

more than the rate the facility received in the prior fiscal year, except any facility that would have been issued a lower rate effective July 1, 2004, than for the fiscal year ending June 30, 2004, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2004. Effective upon receipt of all the necessary federal approvals to secure federal financial participation matching funds associated with the rate increase provided in subdivision (4) of subsection (f) of this section, but in no event earlier than October 1, 2005, and provided the user fee imposed under section 17b-320 is required to be collected, each facility shall receive a rate that is determined in accordance with applicable law and subject to appropriations, except any facility that would have been issued a lower rate effective October 1, 2005, than for the fiscal year ending June 30, 2005, due to interim rate status or agreement with the department, shall be issued such lower rate effective October 1, 2005. Such rate increase shall remain in effect unless: (A) The federal financial participation matching funds associated with the rate increase are no longer available; or (B) the user fee created pursuant to section 17b-320 is not in effect. For the fiscal year ending June 30, 2007, rates in effect for the period ending June 30, 2006, shall remain in effect until September 30, 2006, except any facility that would have been issued a lower rate effective July 1, 2006, than for the fiscal year ending June 30, 2006, due to interim rate status or agreement with the department, shall be issued such lower rate effective July 1, 2006. Effective October 1, 2006, no facility shall receive a rate that is more than four per cent greater than the rate in effect for the facility on September 30, 2006, except for any facility that would have been issued a lower rate effective October 1, 2006, due to interim rate status or agreement with the department, shall be issued such lower rate effective October 1, 2006. For the fiscal years ending June 30, 2010, and June 30, 2011, rates in effect for the period ending June 30, 2009, shall remain in effect until June 30, 2011, except any facility that would have been issued a lower rate for the fiscal year ending June 30, 2010, or the fiscal year ending June 30, 2011, due to interim rate status or agreement with the department, shall be issued such lower rate, except (i) any facility that

would have been issued a lower rate for the fiscal year ending June 30, 2010, or the fiscal year ending June 30, 2011, due to interim rate status or agreement with the Commissioner of Social Services shall be issued such lower rate; and (ii) the commissioner may increase a facility's rate for reasonable costs associated with such facility's compliance with the provisions of section 19a-495a concerning the administration of medication by unlicensed personnel. For the fiscal year ending June 30, 2012, rates in effect for the period ending June 30, 2011, shall remain in effect until June 30, 2012, except that (I) any facility that would have been issued a lower rate for the fiscal year ending June 30, 2012, due to interim rate status or agreement with the Commissioner of Social Services shall be issued such lower rate; and (II) the commissioner may increase a facility's rate for reasonable costs associated with such facility's compliance with the provisions of section 19a-495a concerning the administration of medication by unlicensed personnel. For the fiscal year ending June 30, 2013, the Commissioner of Social Services may, within available appropriations, provide a rate increase to a residential care home. Any facility that would have been issued a lower rate for the fiscal year ending June 30, 2013, due to interim rate status or agreement with the Commissioner of Social Services shall be issued such lower rate. For the fiscal years ending June 30, 2012, and June 30, 2013, the Commissioner of Social Services may provide fair rent increases to any facility that has undergone a material change in circumstances related to fair rent and has an approved certificate of need pursuant to section 17b-352, 17b-353, 17b-354 or 17b-355. Any facility that would have been issued a lower rate for the fiscal year ending June 30, 2014, or the fiscal year ending June 30, 2015, due to interim rate status or agreement with the commissioner, shall be issued such lower rate. The department may, within available appropriations, increase or decrease residential care home rates to reflect the rebasing of facility costs as provided in subsection (a) of this section.

Sec. 5. (NEW) (*Effective October 1, 2014*) The Commissioner of Social Services shall implement the tenth revision of the International Statistical Classification of Diseases and Related Health Problems for

the purposes of all medical assistance programs administered by the Department of Social Services. The Commissioner of Social Services may implement policies and procedures necessary to carry out the provisions of this section while in the process of adopting the policies and procedures as regulations, provided notice of intent to adopt the regulations is published in the Connecticut Law Journal not later than twenty days after the date of implementation.

Sec. 6. Section 17b-239 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2013*):

(a) **[**The rate to be paid by the state to hospitals receiving appropriations granted by the General Assembly and to freestanding chronic disease hospitals, providing services to persons aided or cared for by the state for routine services furnished to state patients, shall be based upon reasonable cost to such hospital, or the charge to the general public for ward services or the lowest charge for semiprivate services if the hospital has no ward facilities, imposed by such hospital, whichever is lowest, except to the extent, if any, that the commissioner determines that a greater amount is appropriate in the case of hospitals serving a disproportionate share of indigent patients. Such rate shall be promulgated annually by the Commissioner of Social Services.**]** On and after July 1, 2013, Medicaid rates paid to acute care and children's hospitals shall be based on diagnosis–related groups established and periodically rebased by the Commissioner of Social Services, provided the Department of Social Services completes a fiscal analysis of the impact of such rate payment system on each hospital. The Commissioner of Social Services shall, in accordance with the provisions of section 11-4a, file a report on the results of the fiscal analysis not later than December 31, 2013, with the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies. The Commissioner of Social Services shall annually determine inpatient rates for each hospital by multiplying diagnostic-related group relative weights by a base rate. Within available

appropriations, the commissioner may, in his or her discretion, make additional payments to hospitals based on criteria to be determined by the commissioner. Nothing contained in this section shall authorize **[**a**]** Medicaid payment by the state **[**for such services**]** to any such hospital in excess of the charges made by such hospital for comparable services to the general public. **[**Notwithstanding the provisions of this section, for the rate period beginning July 1, 2000, rates paid to freestanding chronic disease hospitals and freestanding psychiatric hospitals shall be increased by three per cent. For the rate period beginning July 1, 2001, a freestanding chronic disease hospital or freestanding psychiatric hospital shall receive a rate that is two and one-half per cent more than the rate it received in the prior fiscal year and such rate shall remain effective until December 31, 2002. Effective January 1, 2003, a freestanding chronic disease hospital or freestanding psychiatric hospital shall receive a rate that is two per cent more than the rate it received in the prior fiscal year. Notwithstanding the provisions of this subsection, for the period commencing July 1, 2001, and ending June 30, 2003, the commissioner may pay an additional total of no more than three hundred thousand dollars annually for services provided to long-term ventilator patients. For purposes of this subsection, "long-term ventilator patient" means any patient at a freestanding chronic disease hospital on a ventilator for a total of sixty days or more in any consecutive twelve-month period. Effective July 1, 2007, each freestanding chronic disease hospital shall receive a rate that is four per cent more than the rate it received in the prior fiscal year.**]**

(b) Effective October 1, 1991, the rate to be paid by the state for the cost of special services rendered by such hospitals shall be established annually by the commissioner for each such hospital based on the reasonable cost to each hospital of such services furnished to state patients. Nothing contained in this subsection shall authorize a payment by the state for such services to any such hospital in excess of the charges made by such hospital for comparable services to the general public.

(c) The term "reasonable cost" as used in this section means the cost of care furnished such patients by an efficient and economically operated facility, computed in accordance with accepted principles of hospital cost reimbursement. The commissioner may adjust the rate of payment established under the provisions of this section for the year during which services are furnished to reflect fluctuations in hospital costs. Such adjustment may be made prospectively to cover anticipated fluctuations or may be made retroactive to any date subsequent to the date of the initial rate determination for such year or in such other manner as may be determined by the commissioner. In determining "reasonable cost" the commissioner may give due consideration to allowances for fully or partially unpaid bills, reasonable costs mandated by collective bargaining agreements with certified collective bargaining agents or other agreements between the employer and employees, provided "employees" shall not include persons employed as managers or chief administrators, requirements for working capital and cost of development of new services, including additions to and replacement of facilities and equipment. The commissioner shall not give consideration to amounts paid by the facilities to employees as salary, or to attorneys or consultants as fees, where the responsibility of the employees, attorneys or consultants is to persuade or seek to persuade the other employees of the facility to support or oppose unionization. Nothing in this subsection shall prohibit the commissioner from considering amounts paid for legal counsel related to the negotiation of collective bargaining agreements, the settlement of grievances or normal administration of labor relations.

(d) **[**The state shall also pay to such hospitals for each outpatient clinic and emergency room visit a reasonable rate to be established annually by the commissioner for each hospital, such rate to be determined by the reasonable cost of such services. The emergency room visit rates in effect June 30, 1991, shall remain in effect through June 30, 1993, except those which would have been decreased effective July 1, 1991, or July 1, 1992, shall be decreased.**]** <u>On or after July 1, 2013, hospitals shall be paid for outpatient and emergency room</u>

episodes of care based on prospective rates established by the commissioner in accordance with the Medicare ambulatory payment classification system in conjunction with a state conversion factor, provided the Department of Social Services completes a fiscal analysis of the impact of such rate payment system on each hospital. The Commissioner of Social Services shall, in accordance with the provisions of section 11-4a, file a report on the results of the fiscal analysis not later than December 31, 2013, with the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies. The Medicare ambulatory payment classification system shall be modified to provide payment for services not generally covered by Medicare, including, but not limited to, pediatric, obstetric, neonatal and perinatal services. Nothing contained in this subsection shall authorize a payment by the state for such **[**services**]** episodes of care to any hospital in excess of the charges made by such hospital for comparable services to the general public. **[**For those**]** Those outpatient hospital services that do not have an established Ambulatory Payment Classification code shall be paid on the basis of a ratio of cost to charges, **[**the ratios**]** or the fixed fee in effect **[**June 30, 1991, shall be reduced effective July 1, 1991, by the most recent annual increase in the consumer price index for medical care. For those outpatient hospital services paid on the basis of a ratio of cost to charges, the ratios computed to be effective July 1, 1994, shall be reduced by the most recent annual increase in the consumer price index for medical care. The emergency room visit rates in effect June 30, 1994, shall remain in effect through December 31, 1994**]** as of July 1, 2014. The Commissioner of Social Services shall establish a fee schedule for outpatient hospital services to be effective on and after January 1, 1995, and may annually modify such fee schedule if such modification is needed to ensure that the conversion to an administrative services organization is cost neutral to hospitals in the aggregate and ensures patient access. Utilization may be a factor in determining cost neutrality. **[**for the fiscal year ending June 30, 2013. Except with respect to the rate periods beginning July 1, 1999, and July 1, 2000, such fee

schedule shall be adjusted annually beginning July 1, 1996, to reflect necessary increases in the cost of services. Notwithstanding the provisions of this subsection, the fee schedule for the rate period beginning July 1, 2000, shall be increased by ten and one-half per cent, effective June 1, 2001. Notwithstanding the provisions of this subsection, outpatient rates in effect as of June 30, 2003, shall remain in effect through June 30, 2005. Effective July 1, 2006, subject to available appropriations, the commissioner shall increase outpatient service fees for services that may include clinic, emergency room, magnetic resonance imaging, and computerized axial tomography.**]**

(e) The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, establishing criteria for defining emergency and nonemergency visits to hospital emergency rooms. All nonemergency visits to hospital emergency rooms shall be paid at the hospital's outpatient clinic services rate. Nothing contained in this subsection or the regulations adopted **[**hereunder**]** under this section shall authorize a payment by the state for such services to any hospital in excess of the charges made by such hospital for comparable services to the general public.

(f) **[**On and after October 1, 1984, the state shall pay to an acute care general hospital for the inpatient care of a patient who no longer requires acute care a rate determined by the following schedule: For the first seven days following certification that the patient no longer requires acute care the state shall pay the hospital at a rate of fifty per cent of the hospital's actual cost; for the second seven-day period following certification that the patient no longer requires acute care the state shall pay seventy-five per cent of the hospital's actual cost; for the third seven-day period following certification that the patient no longer requires acute care and for any period of time thereafter, the state shall pay the hospital at a rate of one hundred per cent of the hospital's actual cost.**]** On and after July 1, 1995, no payment shall be made by the state to an acute care general hospital for the inpatient care of a patient who no longer requires acute care and is eligible for

Medicare unless the hospital does not obtain reimbursement from Medicare for that stay.

(g) The Commissioner of Social Services may implement policies and procedures necessary to carry out the provisions of this section while in the process of adopting the policies and procedures as regulations, provided notice of intent to adopt the regulations is published in the Connecticut Law Journal not later than twenty days after the date of implementation.

Sec. 7. Subsection (b) of section 17b-239e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2013*):

(b) The commissioner may establish a blended in-patient hospital case rate that includes services provided to all Medicaid recipients and may exclude certain diagnoses, as determined by the commissioner, if the establishment of such rates is needed to ensure that the conversion to an administrative services organization is cost neutral to hospitals in the aggregate and ensures patient access. Utilization may be a factor in determining cost neutrality. **[**for the fiscal year ending June 30, 2013.**]**

Sec. 8. Subsection (a) of section 17b-242 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2013*):

(a) The Department of Social Services shall determine the rates to be paid to home health care agencies and homemaker-home health aide agencies by the state or any town in the state for persons aided or cared for by the state or any such town. For the period from February 1, 1991, to January 31, 1992, inclusive, payment for each service to the state shall be based upon the rate for such service as determined by the Office of Health Care Access, except that for those providers whose Medicaid rates for the year ending January 31, 1991, exceed the median rate, no increase shall be allowed. For those providers whose rates for the year ending January 31, 1991, are below the median rate, increases

shall not exceed the lower of the prior rate increased by the most recent annual increase in the consumer price index for urban consumers or the median rate. In no case shall any such rate exceed the eightieth percentile of rates in effect January 31, 1991, nor shall any rate exceed the charge to the general public for similar services. Rates effective February 1, 1992, shall be based upon rates as determined by the Office of Health Care Access, except that increases shall not exceed the prior year's rate increased by the most recent annual increase in the consumer price index for urban consumers and rates effective February 1, 1992, shall remain in effect through June 30, 1993. Rates effective July 1, 1993, shall be based upon rates as determined by the Office of Health Care Access except if the Medicaid rates for any service for the period ending June 30, 1993, exceed the median rate for such service, the increase effective July 1, 1993, shall not exceed one per cent. If the Medicaid rate for any service for the period ending June 30, 1993, is below the median rate, the increase effective July 1, 1993, shall not exceed the lower of the prior rate increased by one and one-half times the most recent annual increase in the consumer price index for urban consumers or the median rate plus one per cent. The Commissioner of Social Services shall establish a fee schedule for home health services to be effective on and after July 1, 1994. The commissioner may annually modify such fee schedule if such modification is needed to ensure that the conversion to an administrative services organization is cost neutral to home health care agencies and homemaker-home health aide agencies in the aggregate and ensures patient access. Utilization may be a factor in determining cost neutrality. **[**for the fiscal year ending June 30, 2013.**]** The commissioner shall increase the fee schedule for home health services provided under the Connecticut home-care program for the elderly established under section 17b-342, effective July 1, 2000, by two per cent over the fee schedule for home health services for the previous year. The commissioner may increase any fee payable to a home health care agency or homemaker-home health aide agency upon the application of such an agency evidencing extraordinary costs related to (1) serving persons with AIDS; (2) high-risk maternal and child health

care; (3) escort services; or (4) extended hour services. In no case shall any rate or fee exceed the charge to the general public for similar services. A home health care agency or homemaker-home health aide agency which, due to any material change in circumstances, is aggrieved by a rate determined pursuant to this subsection may, within ten days of receipt of written notice of such rate from the Commissioner of Social Services, request in writing a hearing on all items of aggrievement. The commissioner shall, upon the receipt of all documentation necessary to evaluate the request, determine whether there has been such a change in circumstances and shall conduct a hearing if appropriate. The Commissioner of Social Services shall adopt regulations, in accordance with chapter 54, to implement the provisions of this subsection. The commissioner may implement policies and procedures to carry out the provisions of this subsection while in the process of adopting regulations, provided notice of intent to adopt the regulations is published in the Connecticut Law Journal **[**within**]** not later than twenty days after the date of implementing the policies and procedures. Such policies and procedures shall be valid for not longer than nine months.

Sec. 9. Subsection (a) of section 17b-261m of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2013*):

(a) The Commissioner of Social Services may contract with one or more administrative services organizations to provide care coordination, utilization management, disease management, customer service and review of grievances for recipients of assistance under Medicaid, HUSKY Plan, Parts A and B, and the Charter Oak Health Plan. Such organization may also provide network management, credentialing of providers, monitoring of copayments and premiums and other services as required by the commissioner. Subject to approval by applicable federal authority, the Department of Social Services shall utilize the contracted organization's provider network and billing systems in the administration of the program. In order to

implement the provisions of this section, the commissioner may establish rates of payment to providers of medical services under this section if the establishment of such rates is required to ensure that any contract entered into with an administrative services organization pursuant to this section is cost neutral to such providers in the aggregate and ensures patient access. Utilization may be a factor in determining cost neutrality. **[**for the fiscal year ending June 30, 2013.**]**

Sec. 10. Subsection (a) of section 17b-239c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2013*):

(a) Notwithstanding any provision of the general statutes, on and after July 1, 2011, the Department of Social Services may, within available appropriations, make interim **[**monthly**]** quarterly medical assistance disproportionate share payments to short-term general hospitals. The total amount of interim payments made to such hospitals individually and in the aggregate shall maximize federal matching payments under the medical assistance program as determined by the Department of Social Services, in consultation with the Office of Policy and Management. No payments shall be made under this section to (1) any hospital which, on July 1, 2011, is within the class of hospitals licensed by the Department of Public Health as a children's general hospital, or (2) a short-term acute hospital operated exclusively by the state other than a short-term acute hospital operated by the state as a receiver pursuant to chapter 920. The **[**monthly**]** quarterly interim payment amount for each hospital shall be determined by the Commissioner of Social Services based upon the information submitted by the hospital pursuant to Section 1001(d) of Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Sec. 11. Section 17b-28e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2013*):

(a) The Commissioner of Social Services shall amend the Medicaid

state plan to include, on and after January 1, 2009, hospice services as optional services covered under the Medicaid program. Said state plan amendment shall supersede any regulations of Connecticut state agencies concerning such optional services. **[**From January 1, 2013, to June 30, 2013, inclusive, hospice**]** Hospice services covered under the Medicaid program for individuals who are residents in long-term care facilities shall be paid at a rate that is ninety-five per cent of the facility's per diem rate.

[(b) Effective July 1, 2013, the Commissioner of Social Services shall amend the Medicaid state plan to include foreign language interpreter services provided to any beneficiary with limited English proficiency as a covered service under the Medicaid program. Not later than July 1, 2013, the commissioner shall develop and implement the use of medical billing codes for foreign language interpreter services.

(c) Effective July 1, 2013, the Department of Social Services shall report, in accordance with the provisions of section 11-4a, semi-annually, to the Council on Medical Assistance Program Oversight on the foreign language interpreter services provided to recipients of benefits under the program.**]**

[(d)**]** (b) Not later than October 1, 2011, the Commissioner of Social Services shall amend the Medicaid state plan to include podiatry as an optional service under the Medicaid program.

[(e) The Commissioner of Social Services shall amend the Medicaid state plan to provide that chiropractic services shall be covered under the Medicaid program only to the extent required by federal law.**]**

Sec. 12. Section 17b-261 of the general statutes is amended by adding subsection (k) as follows (*Effective January 1, 2014*):

(NEW) (k) In addition to persons eligible for medical assistance under the provisions of subsections (a) to (j), inclusive, of this section, on and after January 1, 2014, medical assistance shall be provided without an asset test to low-income adults whose income does not

exceed one hundred thirty-three per cent of the federal poverty level, in accordance with Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act. In determining eligibility, the commissioner shall not consider as income Aid and Attendance pension benefits granted to a veteran, as defined in section 27-103, or the surviving spouse of such veteran.

Sec. 13. Section 17b-256f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2014*):

[Beginning March 1, 2012, and annually thereafter, the**]** The Commissioner of Social Services shall increase income disregards used to determine eligibility by the Department of Social Services for the federal **[**Specified Low-Income Medicare Beneficiary, the**]** Qualified Medicare Beneficiary, the Specified Low-Income Medicare Beneficiary and the Qualifying Individual **[**Programs**]** programs, administered in accordance with the provisions of 42 USC 1396d(p), by **[**an amount that equalizes the income levels and deductions used to determine eligibility for said programs with income levels and deductions used to determine eligibility for the ConnPACE program under subsection (a) of section 17b-492**]** such amounts that shall result in persons with income that is (1) less than two hundred eleven per cent of the federal poverty level qualifying for the Qualified Medicare Beneficiary program, (2) at or above two hundred eleven per cent of the federal poverty level but less than two hundred thirty-one per cent of the federal poverty level qualifying for the Specified Low-Income Medicare Beneficiary program, and (3) at or above two hundred thirty-one per cent of the federal poverty level but less than two hundred forty-six per cent of the federal poverty level qualifying for the Qualifying Individual program. The commissioner shall not apply an asset test for eligibility under the Medicare Savings Program. The commissioner shall not consider as income Aid and Attendance pension benefits granted to a veteran, as defined in section 27-103, or the surviving spouse of such veteran. The Commissioner of Social Services, pursuant to section 17b-10, may implement policies and procedures to administer the provisions of this section while in the

process of adopting such policies and procedures in regulation form, provided the commissioner prints notice of the intent to adopt the regulations in the Connecticut Law Journal not later than twenty days after the date of implementation. Such policies and procedures shall be valid until the time final regulations are adopted.

Sec. 14. Section 17b-551 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2014*):

Eligibility for participation in the program shall be limited to a resident who is enrolled in Medicare Part B whose annual income does not exceed **[**one hundred sixty-five per cent of the qualifying income level established in the ConnPACE program, pursuant to subsection (a) of section 17b-492**]** forty-three thousand five hundred sixty dollars or if such resident has a spouse, the combined income of such resident and his spouse does not exceed **[**one hundred sixty-five per cent of the qualifying income level established in the ConnPACE program, pursuant to subsection (a) of section 17b-492**]** fifty-eight thousand seven hundred forty dollars. On January 1, 2014, and annually thereafter, the commissioner shall increase the income limit established under this subsection over that of the previous fiscal year to reflect the annual inflation adjustment in Social Security income, if any. Each such adjustment shall be determined to the nearest one hundred dollars.

Sec. 15. Section 17b-552 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2014*):

(a) A health care provider shall limit charges for care, treatment, service or equipment covered by Medicare Part B under Title XVIII of the Social Security Act, as amended, provided to a Medicare beneficiary who meets the eligibility requirements specified in section 17b-551, as amended by this act, to the reasonable charge for the care, treatment, service or equipment provided as determined by the United States Secretary of Health and Human Services. No health care provider shall collect from such qualified beneficiary any amount in

excess of the approved reasonable charge. Any violation of this subsection shall constitute grounds for the assessment of a civil penalty in accordance with subdivision (6) of subsection (a) of section 19a-17. Any complaint alleging a violation of this section shall be made to the Department of Public Health or the appropriate professional licensing board or commission.

(b) The Commissioner of Social Services shall adopt regulations in accordance with the provisions of chapter 54, necessary to administer the program and to determine eligibility in accordance with the provisions of section 17b-551, as amended by this act.

[(c) All health care providers shall accept the identification card issued for the ConnPACE program pursuant to sections 17b-490 to 17b-498, inclusive, as a substitute for a Medicare assignment card.**]**

Sec. 16. Subsection (a) of section 17b-278i of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Customized wheelchairs shall be covered under the Medicaid program only when a standard wheelchair **[**will**]** does not meet an individual's needs as determined by the Department of Social Services. **[**Assessment of the need for a customized wheelchair may be performed by a vendor or nursing facility only if specifically requested by the department.**]** Wheelchair repairs and parts replacements may be subject to review and approval by the department. Refurbished wheelchairs, parts and components shall be utilized whenever practicable.

Sec. 17. Subsection (a) of section 17b-340c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The Commissioner of Social Services may, upon the request of a nursing facility providing services eligible for payment under the medical assistance program, **[**and after consultation with the Secretary

of the Office of Policy and Management,**]** make a payment to such nursing facility in advance of normal bill payment processing. Except as provided in subsection (b) of this section, (1) such advance shall not exceed estimated amounts due to such nursing facility for services provided to eligible recipients over the most recent two-month period, and (2) the commissioner shall recover such payment through reductions to payments due to such nursing facility or cash receipt not later than ninety days after issuance of such payment. The commissioner shall take prudent measures to assure that such advance payments are not provided to any nursing facility that is at risk of bankruptcy or insolvency, and may execute agreements appropriate for the security of repayment.

Sec. 18. Section 17a-22h of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2013*):

(a) The Commissioners of Social Services, Children and Families, and Mental Health and Addiction Services shall develop and implement an integrated behavioral health service system for Medicaid and HUSKY Plan **[**Parts A and**]** Part B members and children enrolled in the voluntary services program operated by the Department of Children and Families and may, at the discretion of the commissioners, include: (1) Other children, adolescents and families served by the Department of Children and Families or the Court Support Services Division of the Judicial Branch; and (2) **[**Medicaid recipients who are not enrolled in HUSKY Plan Part A; and (3)**]** Charter Oak Health Plan members. The integrated behavioral health service system shall be known as the Behavioral Health Partnership. The Behavioral Health Partnership shall seek to increase access to quality behavioral health services by: (A) Expanding individualized, family-centered and community-based services; (B) maximizing federal revenue to fund behavioral health services; (C) reducing unnecessary use of institutional and residential services for children and adults; (D) capturing and investing enhanced federal revenue and savings derived from reduced residential services and increased

community-based services for HUSKY Plan Parts A and B recipients; (E) improving administrative oversight and efficiencies; and (F) monitoring individual outcomes and provider performance, taking into consideration the acuity of the patients served by each provider, and overall program performance.

(b) The Behavioral Health Partnership shall operate in accordance with the financial requirements specified in this subsection. Prior to the conversion of any grant-funded services to a rate-based, fee-for-service payment system, the Department of Social Services, the Department of Children and Families and the Department of Mental Health and Addiction Services shall submit documentation verifying that the proposed rates seek to cover the reasonable cost of providing services to the Behavioral Health Partnership Oversight Council, established pursuant to section 17a-22j, as amended by this act.

Sec. 19. Section 17a-22p of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2013*):

(a) The Departments of Children and Families, Social Services and Mental Health and Addiction Services shall enter into one or more joint contracts or agreements with an administrative services organization or organizations to perform eligibility verification, utilization management, intensive care management, quality management, coordination of medical and behavioral health services, provider network development and management, recipient and provider services and reporting.

(b) Claims under the Behavioral Health Partnership shall be paid by the Department of Social Services' Medicaid management information systems vendor, except that the Department of Children and Families and the Department of Mental Health and Addiction Services may, at their discretion, continue to use existing claims payment systems.

(c) **[**Administrative services organizations**]** An administrative services organization shall authorize services, based solely on medical

necessity, as defined in section 17b-259b. Such organization shall use guidelines established by the clinical management committee, established pursuant to section 17a-22k, **[**Administrative services organizations may make exceptions to the guidelines when requested by a member, or the member's legal guardian or service provider, and determined by the administrative services organization to be in the best interest of the member**]** provided such guidelines may only be used as a basis for expeditiously approving a request for services. If a request for services does not meet such guidelines, an administrative services organization may deny the request based solely on the request not being deemed medically necessary, as defined in section 17b-259b. Decisions regarding the interpretation of such guidelines shall be made by the Departments of Children and Families, Social Services and Mental Health and Addiction Services. No administrative services organization shall have any financial incentive to approve, deny or reduce services. Administrative services organizations shall ensure that service providers and persons seeking services have timely access to program information and timely responses to inquiries, including inquiries concerning the clinical guidelines for services.

(d) **[**The**]** An administrative services organization for Medicaid and HUSKY Plan **[**Parts A and**]** Part B shall provide or arrange for on-site assistance to facilitate the appropriate placement, as soon as practicable, of children with behavioral health diagnoses who the administrative services organization knows to have been in an emergency department for over forty-eight hours. The administrative services organization shall provide or arrange for on-site assistance to arrange for the discharge or appropriate placement, as soon as practicable, for children who the administrative services organization knows to have remained in an inpatient hospital unit for more than five days longer than is medically necessary, as agreed by the administrative services organization and the hospital.

(e) The Departments of Children and Families, Social Services and Mental Health and Addiction Services shall develop, in consultation

with the Behavioral Health Partnership, a comprehensive plan for monitoring the performance of administrative services organizations which shall include data on service authorizations, individual outcomes, appeals, outreach and accessibility, comments from program participants compiled from written surveys and face-to-face interviews.

(f) The Behavioral Health Partnership shall establish policies to coordinate benefits received under the partnership with other benefits received under Medicaid. Such policies shall specify a coordinated delivery of both physical and behavioral health care. The policies shall be submitted to the Behavioral Health Partnership Oversight Council for review and comment.

Sec. 20. Section 17b-10a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2014*):

The Commissioner of Social Services, pursuant to section 17b-10, may implement policies and procedures necessary to administer section 17b-197, subsection (d) of section 17b-266, section 17b-280a **[**,**]** and subsection (a) of section 17b-295, **[**and subsection (c) of section 17b-311,**]** while in the process of adopting such policies and procedures as regulation, provided the commissioner prints notice of intent to adopt regulations in the Connecticut Law Journal not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted.

Sec. 21. Subsection (b) of section 38a-556a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2014*):

(b) Said association shall, in consultation with the Insurance Commissioner and the Healthcare Advocate, develop, within available appropriations, a web site, telephone number or other method to serve as a clearinghouse for information about individual and small

employer health insurance policies and health care plans that are available to consumers in this state, including, but not limited to, the Medicaid program, the HUSKY Plan, **[**the Charter Oak Health Plan set forth in section 17b-311,**]** the Municipal Employee Health Insurance Plan set forth in subsection (i) of section 5-259, and any individual or small employer health insurance policies or health care plans an insurer, health care center or other entity chooses to list with the Connecticut Clearinghouse.

Sec. 22. Subsection (a) of section 29-1s of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2014*):

(a) (1) Wherever the term "Department of Public Safety" is used in the following general statutes, the term "Department of Emergency Services and Public Protection" shall be substituted in lieu thereof; and (2) wherever the term "Commissioner of Public Safety" is used in the following general statutes, the term "Commissioner of Emergency Services and Public Protection" shall be substituted in lieu thereof: 1-24, 1-84b, 1-217, 2-90b, 3-2b, 4-68m, 4a-2a, 4a-18, 4a-67d, 4b-1, 4b-130, 5-142, 5-146, 5-149, 5-150, 5-169, 5-173, 5-192f, 5-192t, 5-246, 6-32g, 7-169, 7-285, 7-294f to 7-294h, inclusive, 7-294*l*, 7-294n, 7-294y, 7-425, 9-7a, 10-233h, 12-562, 12-564a, 12-586f, 12-586g, 13a-123, 13b-69, 13b-376, 14-10, 14-64, 14-67m, 14-67w, 14-103, 14-108a, 14-138, 14-152, 14-163c, 14-211a, 14-212a, 14-212f, 14-219c, 14-227a, 14-227c, 14-267a, 14-270c to 14-270f, inclusive, 14-283, 14-291, 14-298, 14-315, 15-98, 15-140r, 15-140u, 16-256g, 16a-103, 17a-105a, 17a-106a, 17a-500, 17b-90, as amended by this act, 17b-137, 17b-192, 17b-225, 17b-279, **[**17b-490,**]** 18-87k, 19a-112a, 19a-112f, 19a-179b, 19a-409, 19a-904, 20-12c, 20-327b, 21a-36, 21a-283, 22a-2, 23-8b, 23-18, 26-5, 26-67b, 27-19a, 27-107, 28-25b, 28-27, 28-27a, 28-30a, 29-1c, 29-1e to 29-1h, inclusive, 29-1q, 29-1zz, 29-2, 29-2a, 29-2b, 29-3a, 29-4a, 29-6a, 29-7, 29-7b, 29-7c, 29-7h, 29-7m, 29-7n, 29-8, 29-10, 29-10a, 29-10c, 29-11, 29-12, 29-17a, 29-17b, 29-17c, 29-18 to 29-23a, inclusive, 29-25, 29-26, 29-28, 29-28a, 29-30 to 29-32, inclusive, 29-32b, 29-33, 29-36f to 29-36i, inclusive, 29-36k, 29-36m, 29-36n, 29-37a, 29-37f, 29-38b,

29-38e, 29-38f, 29-108b, 29-143i, 29-143j, 29-145 to 29-151, inclusive, 29-152f to 29-152j, inclusive, 29-152m, 29-152o, 29-152u, 29-153, 29-155d, 29-156a, 29-161g to 29-161i, inclusive, 29-161k to 29-161m, inclusive, 29-161o to 29-161t, inclusive, 29-161v to 29-161z, inclusive, 29-163, 29-164g, 29-166, 29-176 to 29-179, inclusive, 29-179f to 29-179h, 31-275, 38a-18, 38a-356, 45a-63, 46a-4b, 46a-170, 46b-15a, 46b-38d, 46b-38f, 51-5c, 51-10c, 51-51o, 51-277a, 52-11, 53-39a, 53-134, 53-199, 53-202, 53-202b, 53-202c, 53-202g, 53-202*l*, 53-202n, 53-202o, 53-278c, 53-341b, 53a-3, 53a-30, 53a-54b, 53a-130, 53a-130a, 54-1f, 54-1*l*, 54-36e, 54-36i, 54-36n, 54-47aa, 54-63c, 54-76*l*, 54-86k, 54-102g to 54-102j, inclusive, 54-102m, 54-102pp, 54-142j, 54-222a, 54-240, 54-240m, 54-250 to 54-258, inclusive, 54-259a, 54-260b, and 54-300.

Sec. 23. Subsection (e) of section 12-746 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2014*):

(e) Amounts rebated pursuant to this section shall not be considered income for purposes of sections 8-119*l*, 12-170d, 12-170aa, **[**17b-490,**]** 17b-550, 17b-812, 47-88d and 47-287.

Sec. 24. Subsection (b) of section 10a-132e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2014*):

(b) The program established pursuant to subsection (a) of this section shall: (1) Arrange for licensed physicians, pharmacists and nurses to conduct in person educational visits with prescribing practitioners, utilizing evidence-based materials, borrowing methods from behavioral science and educational theory and, when appropriate, utilizing pharmaceutical industry data and outreach techniques; (2) inform prescribing practitioners about drug marketing that is designed to prevent competition to brand name drugs from generic or other therapeutically-equivalent pharmaceutical alternatives or other evidence-based treatment options; and (3) provide outreach and education to licensed physicians and other health care

practitioners who are participating providers in state-funded health care programs, including, but not limited to, Medicaid, the HUSKY Plan, Parts A and B, **[**the Charter Oak Health Plan, the ConnPACE program,**]** the Department of Correction inmate health services program and the state employees' health insurance plan.

Sec. 25. Subsection (a) of section 17a-22f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2014*):

(a) The Commissioner of Social Services may, with regard to the provision of behavioral health services provided pursuant to a state plan under Title XIX or Title XXI of the Social Security Act: **[**, or under the Charter Oak Health Plan:**]** (1) Contract with one or more administrative services organizations to provide clinical management, provider network development and other administrative services; (2) delegate responsibility to the Department of Children and Families for the clinical management portion of such administrative contract or contracts that pertain to HUSKY Plan Parts A and B, and other children, adolescents and families served by the Department of Children and Families; and (3) delegate responsibility to the Department of Mental Health and Addiction Services for the clinical management portion of such administrative contract or contracts that pertain to Medicaid recipients who are not enrolled in HUSKY Plan Part A. **[**and recipients enrolled in the Charter Oak Health Plan.**]**

Sec. 26. Subsection (a) of section 17a-22h of the general statutes, as amended by section 18 of this act, is repealed and the following is substituted in lieu thereof (*Effective January 1, 2014*):

(a) The Commissioners of Social Services, Children and Families, and Mental Health and Addiction Services shall develop and implement an integrated behavioral health service system for Medicaid and HUSKY Plan Part B members and children enrolled in the voluntary services program operated by the Department of Children and Families and may, at the discretion of the commissioners,

include **[**: (1) Other**]** other children, adolescents and families served by the Department of Children and Families or the Court Support Services Division of the Judicial Branch. **[**; and (2) Charter Oak Health Plan members.**]** The integrated behavioral health service system shall be known as the Behavioral Health Partnership. The Behavioral Health Partnership shall seek to increase access to quality behavioral health services by: (A) Expanding individualized, family-centered and community-based services; (B) maximizing federal revenue to fund behavioral health services; (C) reducing unnecessary use of institutional and residential services for children and adults; (D) capturing and investing enhanced federal revenue and savings derived from reduced residential services and increased community-based services for HUSKY Plan Parts A and B recipients; (E) improving administrative oversight and efficiencies; and (F) monitoring individual outcomes and provider performance, taking into consideration the acuity of the patients served by each provider, and overall program performance.

Sec. 27. Subsection (a) of section 17b-28 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2014*):

(a) There is established a Council on Medical Assistance Program Oversight which shall advise the Commissioner of Social Services on the planning and implementation of the health care delivery system for the following health care programs: The HUSKY Plan, Parts A and B **[**, the Charter Oak Health Plan**]** and the Medicaid program, including, but not limited to, the portions of the program serving low income adults, the aged, blind and disabled individuals, individuals who are dually eligible for Medicaid and Medicare and individuals with preexisting medical conditions. The council shall monitor planning and implementation of matters related to Medicaid care management initiatives including, but not limited to, (1) eligibility standards, (2) benefits, (3) access, (4) quality assurance, (5) outcome measures, and (6) the issuance of any request for proposal by the

Department of Social Services for utilization of an administrative services organization in connection with such initiatives.

Sec. 28. Subsection (a) of section 17b-261m of the general statutes, as amended by section 9 of this act, is repealed and the following is substituted in lieu thereof (*Effective January 1, 2014*):

(a) The Commissioner of Social Services may contract with one or more administrative services organizations to provide care coordination, utilization management, disease management, customer service and review of grievances for recipients of assistance under Medicaid **[**,**]** and HUSKY Plan, Parts A and B. **[**, and the Charter Oak Health Plan.**]** Such organization may also provide network management, credentialing of providers, monitoring of copayments and premiums and other services as required by the commissioner. Subject to approval by applicable federal authority, the Department of Social Services shall utilize the contracted organization's provider network and billing systems in the administration of the program. In order to implement the provisions of this section, the commissioner may establish rates of payment to providers of medical services under this section if the establishment of such rates is required to ensure that any contract entered into with an administrative services organization pursuant to this section is cost neutral to such providers in the aggregate and ensures patient access. Utilization may be a factor in determining cost neutrality.

Sec. 29. Section 17b-274 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2014*):

(a) The Division of Criminal Justice shall periodically investigate pharmacies to ensure that the state is not billed for a brand name drug product when a less expensive generic substitute drug product is dispensed to a Medicaid recipient. The Commissioner of Social Services shall cooperate and provide information as requested by such division.

(b) A licensed medical practitioner may specify in writing or by a telephonic or electronic communication that there shall be no substitution for the specified brand name drug product in any prescription for a Medicaid **[**or ConnPACE**]** recipient, provided (1) the practitioner specifies the basis on which the brand name drug product and dosage form is medically necessary in comparison to a chemically equivalent generic drug product substitution, and (2) the phrase "brand medically necessary" shall be in the practitioner's handwriting on the prescription form or, if the prohibition was communicated by telephonic communication, in the pharmacist's handwriting on such form, and shall not be preprinted or stamped or initialed on such form. If the practitioner specifies by telephonic communication that there shall be no substitution for the specified brand name drug product in any prescription for a Medicaid **[**or ConnPACE**]** recipient, written certification in the practitioner's handwriting bearing the phrase "brand medically necessary" shall be sent to the dispensing pharmacy within ten days. A pharmacist shall dispense a generically equivalent drug product for any drug listed in accordance with the Code of Federal Regulations Title 42 Part 447.332 for a drug prescribed for a Medicaid, or state-administered general assistance **[**, or ConnPACE**]** recipient unless the phrase "brand medically necessary" is ordered in accordance with this subsection and such pharmacist has received approval to dispense the brand name drug product in accordance with subsection (c) of this section.

(c) The Commissioner of Social Services shall implement a procedure by which a pharmacist shall obtain approval from an independent pharmacy consultant acting on behalf of the Department of Social Services, under an administrative services only contract, whenever the pharmacist dispenses a brand name drug product to a Medicaid **[**or ConnPACE**]** recipient and a chemically equivalent generic drug product substitution is available. The length of authorization for brand name drugs shall be in accordance with section 17b-491a. In cases where the brand name drug is less costly than the chemically equivalent generic drug when factoring in manufacturers'

rebates, the pharmacist shall dispense the brand name drug. If such approval is not granted or denied within two hours of receipt by the commissioner of the request for approval, it shall be deemed granted. Notwithstanding any provision of this section, a pharmacist shall not dispense any initial maintenance drug prescription for which there is a chemically equivalent generic substitution that is for less than fifteen days without the department's granting of prior authorization, provided prior authorization shall not otherwise be required for atypical antipsychotic drugs if the individual is currently taking such drug at the time the pharmacist receives the prescription. The pharmacist may appeal a denial of reimbursement to the department based on the failure of such pharmacist to substitute a generic drug product in accordance with this section.

(d) A licensed medical practitioner shall disclose to the Department of Social Services or such consultant, upon request, the basis on which the brand name drug product and dosage form is medically necessary in comparison to a chemically equivalent generic drug product substitution. The Commissioner of Social Services shall establish a procedure by which such a practitioner may appeal a determination that a chemically equivalent generic drug product substitution is required for a Medicaid **[**or ConnPACE**]** recipient.

Sec. 30. Section 17b-274a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2014*):

The Commissioner of Social Services may establish maximum allowable costs to be paid under the Medicaid **[**, ConnPACE**]** and Connecticut AIDS drug assistance programs for generic prescription drugs based on, but not limited to, actual acquisition costs. The department shall implement and maintain a procedure to review and update the maximum allowable cost list at least annually, and shall report annually to the joint standing committee of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies on its activities pursuant to this section.

Sec. 31. Subsection (a) of section 17b-274c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2014*):

(a) The Commissioner of Social Services may establish a voluntary mail order option for any maintenance prescription drug covered under the Medicaid **[**, ConnPACE**]** or Connecticut AIDS drug assistance programs.

Sec. 32. Subsection (e) of section 17b-274d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2014*):

(e) The Department of Social Services, in consultation with the Pharmaceutical and Therapeutics Committee, may adopt a preferred drug **[**lists**]** list for use in the Medicaid **[**and ConnPACE programs**]** program. To the extent feasible, the department shall review all drugs included on the preferred drug **[**lists**]** list at least every twelve months, and may recommend additions to, and deletions from, the preferred drug **[**lists**]** list, to ensure that the preferred drug **[**lists provide**]** list provides for medically appropriate drug therapies for Medicaid **[**and ConnPACE**]** patients. **[**For the fiscal year ending June 30, 2004, such drug lists shall be limited to use in the Medicaid and ConnPACE programs and cover three classes of drugs, including proton pump inhibitors and two other classes of drugs determined by the Commissioner of Social Services. Not later than June 30, 2005, the**]** The Department of Social Services, in consultation with the Pharmaceutical and **[**Therapeutic**]** Therapeutics Committee, shall expand such drug **[**lists**]** list to include other classes of drugs, except as provided in subsection (f) of this section, in order to achieve savings reflected in the amounts appropriated to the department, for the various components of the program, in the state budget act.

Sec. 33. Section 17b-274e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2014*):

A pharmacist, when filling a prescription under the Medicaid **[**, ConnPACE**]** or Connecticut AIDS drug assistance programs, shall fill such prescription utilizing the most cost-efficient dosage, consistent with the prescription of a prescribing practitioner as defined in section 20-571, unless such pharmacist receives permission to do otherwise pursuant to the prior authorization requirements set forth in sections 17b-274, as amended by this act, and 17b-491a.

Sec. 34. Subsection (a) of section 17b-280 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2014*):

(a) The state shall reimburse for all legend drugs provided under medical assistance programs administered by the Department of Social Services at the lower of (1) the rate established by the Centers for Medicare and Medicaid Services as the federal acquisition cost, (2) the average wholesale price minus sixteen per cent, or (3) an equivalent percentage as established under the Medicaid state plan. Notwithstanding the provisions of this section, contingent upon federal approval, on and after October 1, 2012, for independent pharmacies, the state shall reimburse for such legend drugs at the lower of (A) the rate established by the Centers for Medicare and Medicaid Services as the federal acquisition cost, (B) the average wholesale price minus fifteen per cent, or (C) an equivalent percentage as established under the Medicaid state plan. The state shall pay a professional fee of one dollar and seventy cents to licensed pharmacies for each prescription dispensed to a recipient of benefits under a medical assistance program administered by the Department of Social Services in accordance with federal regulations. On and after September 4, 1991, payment for legend and nonlegend drugs provided to Medicaid recipients shall be based upon the actual package size dispensed. Effective October 1, 1991, reimbursement for over-the-counter drugs for such recipients shall be limited to those over-the-counter drugs and products published in the Connecticut Formulary, or the cross reference list, issued by the commissioner. The cost of all

over-the-counter drugs and products provided to residents of nursing facilities, chronic disease hospitals, and intermediate care facilities for the mentally retarded shall be included in the facilities' per diem rate. Notwithstanding the provisions of this subsection, no dispensing fee shall be issued for a prescription drug dispensed to a **[**ConnPACE or**]** Medicaid recipient who is a Medicare Part D beneficiary when the prescription drug is a Medicare Part D drug, as defined in Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Sec. 35. Section 17b-429 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2014*):

The Commissioner of Social Services shall, within available appropriations, make information available to senior citizens and disabled persons concerning any pharmaceutical company's drug program for indigent persons by utilizing the **[**ConnPACE program, the**]** CHOICES health insurance assistance program, as defined in section 17b-427, and Infoline of Connecticut to deliver such information.

Sec. 36. Section 17b-491b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2014*):

The maximum allowable cost paid for Factor VIII pharmaceuticals under the Medicaid **[**and ConnPACE programs**]** program shall be the actual acquisition cost plus eight per cent. The Commissioner of Social Services may designate specific suppliers of Factor VIII pharmaceuticals from which a dispensing pharmacy shall order the prescription to be delivered to the pharmacy and billed by the supplier to the Department of Social Services. If the commissioner so designates specific suppliers of Factor VIII pharmaceuticals, the department shall pay the dispensing pharmacy a handling fee equal to eight per cent of the actual acquisition cost for such prescription.

Sec. 37. Subsection (c) of section 20-619 of the general statutes is

repealed and the following is substituted in lieu thereof (*Effective January 1, 2014*):

(c) A prescribing practitioner may specify in writing or by a telephonic or other electronic communication that there shall be no substitution for the specified brand name drug product in any prescription, provided (1) in any prescription for a Medicaid **[**or ConnPACE**]** recipient, such practitioner specifies the basis on which the brand name drug product and dosage form is medically necessary in comparison to a chemically equivalent generic name drug product substitution, and (2) the phrase "BRAND MEDICALLY NECESSARY", shall be in the practitioner's handwriting on the prescription form or on an electronically produced copy of the prescription form or, if the prohibition was communicated by telephonic or other electronic communication that did not reproduce the practitioner's handwriting, a statement to that effect appears on the form. The phrase "BRAND MEDICALLY NECESSARY" shall not be preprinted or stamped or initialed on the form. If the practitioner specifies by telephonic or other electronic communication that did not reproduce the practitioner's handwriting that there shall be no substitution for the specified brand name drug product in any prescription for a Medicaid **[**or ConnPACE**]** recipient, written certification in the practitioner's handwriting bearing the phrase "BRAND MEDICALLY NECESSARY" shall be sent to the dispensing pharmacy not later than ten days after the date of such communication.

Sec. 38. Subdivision (11) of subsection (b) of section 17a-22j of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2014*):

(11) One representative from each administrative services organization under contract with the Department of Social Services to provide such services for recipients of assistance under Medicaid **[**,**]** and HUSKY Plan, **[**Part A and Part B and the Charter Oak Health Plan,**]** Part B to be nonvoting ex-officio members.

Sec. 39. Subsection (b) of section 17b-90 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2014*):

(b) No person shall, except for purposes directly connected with the administration of programs of the Department of Social Services and in accordance with the regulations of the commissioner, solicit, disclose, receive or make use of, or authorize, knowingly permit, participate in or acquiesce in the use of, any list of the names of, or any information concerning, persons applying for or receiving assistance from the Department of Social Services or persons participating in a program administered by said department, directly or indirectly derived from the records, papers, files or communications of the state or its subdivisions or agencies, or acquired in the course of the performance of official duties. The Commissioner of Social Services shall disclose (1) to any authorized representative of the Labor Commissioner such information directly related to unemployment compensation, administered pursuant to chapter 567 or information necessary for implementation of sections 17b-688b, 17b-688c and 17b-688h and section 122 of public act 97-2 of the June 18 special session, (2) to any authorized representative of the Commissioner of Mental Health and Addiction Services any information necessary for the implementation and operation of the basic needs supplement program, or the Medicaid program for low-income adults, **[**established**]** administered pursuant to section **[**17b-261n**]** 17b-261, as amended by this act, (3) to any authorized representative of the Commissioner of Administrative Services or the Commissioner of Emergency Services and Public Protection such information as the Commissioner of Social Services determines is directly related to and necessary for the Department of Administrative Services or the Department of Emergency Services and Public Protection for purposes of performing their functions of collecting social services recoveries and overpayments or amounts due as support in social services cases, investigating social services fraud or locating absent parents of public assistance recipients, (4) to any authorized representative of the Commissioner of Children and

Families necessary information concerning a child or the immediate family of a child receiving services from the Department of Social Services, including safety net services, if the Commissioner of Children and Families or the Commissioner of Social Services has determined that imminent danger to such child's health, safety or welfare exists to target the services of the family services programs administered by the Department of Children and Families, (5) to a town official or other contractor or authorized representative of the Labor Commissioner such information concerning an applicant for or a recipient of assistance under state-administered general assistance deemed necessary by the Commissioner of Social Services and the Labor Commissioner to carry out their respective responsibilities to serve such persons under the programs administered by the Labor Department that are designed to serve applicants for or recipients of state-administered general assistance, (6) to any authorized representative of the Commissioner of Mental Health and Addiction Services for the purposes of the behavioral health managed care program established by section 17a-453, (7) to any authorized representative of the Commissioner of Public Health to carry out his or her respective responsibilities under programs that regulate child day care services or youth camps, (8) to a health insurance provider, in IV-D support cases, as defined in subdivision (13) of subsection (b) of section 46b-231, information concerning a child and the custodial parent of such child that is necessary to enroll such child in a health insurance plan available through such provider when the noncustodial parent of such child is under court order to provide health insurance coverage but is unable to provide such information, provided the Commissioner of Social Services determines, after providing prior notice of the disclosure to such custodial parent and an opportunity for such parent to object, that such disclosure is in the best interests of the child, (9) to any authorized representative of the Department of Correction, in IV-D support cases, as defined in subdivision (13) of subsection (b) of section 46b-231, information concerning noncustodial parents that is necessary to identify inmates or parolees with IV-D support cases who may benefit from Department of Correction

educational, training, skill building, work or rehabilitation programming that will significantly increase an inmate's or parolee's ability to fulfill such inmate's support obligation, (10) to any authorized representative of the Judicial Branch, in IV-D support cases, as defined in subdivision (13) of subsection (b) of section 46b-231, information concerning noncustodial parents that is necessary to: (A) Identify noncustodial parents with IV-D support cases who may benefit from educational, training, skill building, work or rehabilitation programming that will significantly increase such parent's ability to fulfill such parent's support obligation, (B) assist in the administration of the Title IV-D child support program, or (C) assist in the identification of cases involving family violence, or (11) to any authorized representative of the State Treasurer, in IV-D support cases, as defined in subdivision (13) of subsection (b) of section 46b-231, information that is necessary to identify child support obligors who owe overdue child support prior to the Treasurer's payment of such obligors' claim for any property unclaimed or presumed abandoned under part III of chapter 32. No such representative shall disclose any information obtained pursuant to this section, except as specified in this section. Any applicant for assistance provided through said department shall be notified that, if and when such applicant receives benefits, the department will be providing law enforcement officials with the address of such applicant upon the request of any such official pursuant to section 17b-16a.

Sec. 40. Section 17b-260d of the general statutes is repealed. (*Effective July 1, 2013*)

Sec. 41. Sections 17b-261n, 17b-311, 17b-490, 17b-491, 17b-492 and 17b-493 to 17b-498, inclusive, of the general statutes are repealed. (*Effective January 1, 2014*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2013*	10-295(b)

Sec. 2	*July 1, 2013*	17b-607
Sec. 3	*July 1, 2013*	17b-340(f)(4)
Sec. 4	*July 1, 2013*	17b-340(h)(1)
Sec. 5	*October 1, 2014*	New section
Sec. 6	*July 1, 2013*	17b-239
Sec. 7	*July 1, 2013*	17b-239e(b)
Sec. 8	*July 1, 2013*	17b-242(a)
Sec. 9	*July 1, 2013*	17b-261m(a)
Sec. 10	*July 1, 2013*	17b-239c(a)
Sec. 11	*July 1, 2013*	17b-28e
Sec. 12	*January 1, 2014*	17b-261
Sec. 13	*January 1, 2014*	17b-256f
Sec. 14	*January 1, 2014*	17b-551
Sec. 15	*January 1, 2014*	17b-552
Sec. 16	*from passage*	17b-278i(a)
Sec. 17	*from passage*	17b-340c(a)
Sec. 18	*July 1, 2013*	17a-22h
Sec. 19	*July 1, 2013*	17a-22p
Sec. 20	*January 1, 2014*	17b-10a
Sec. 21	*January 1, 2014*	38a-556a(b)
Sec. 22	*January 1, 2014*	29-1s(a)
Sec. 23	*January 1, 2014*	12-746(e)
Sec. 24	*January 1, 2014*	10a-132e(b)
Sec. 25	*January 1, 2014*	17a-22f(a)
Sec. 26	*January 1, 2014*	17a-22h(a)
Sec. 27	*January 1, 2014*	17b-28(a)
Sec. 28	*January 1, 2014*	17b-261m(a)
Sec. 29	*January 1, 2014*	17b-274
Sec. 30	*January 1, 2014*	17b-274a
Sec. 31	*January 1, 2014*	17b-274c(a)
Sec. 32	*January 1, 2014*	17b-274d(e)
Sec. 33	*January 1, 2014*	17b-274e
Sec. 34	*January 1, 2014*	17b-280(a)
Sec. 35	*January 1, 2014*	17b-429
Sec. 36	*January 1, 2014*	17b-491b
Sec. 37	*January 1, 2014*	20-619(c)
Sec. 38	*January 1, 2014*	17a-22j(b)(11)
Sec. 39	*January 1, 2014*	17b-90(b)
Sec. 40	*July 1, 2013*	Repealer section
Sec. 41	*January 1, 2014*	Repealer section

Statement of Legislative Commissioners:
In section 2(c), language was redrafted to conform with the style of the general statutes; in section 13, new language was redrafted for clarity and consistency with federal law; in section 28(a), the phrase "provided the Department of Social Services completes a fiscal analysis prior to implementation of the impact on each such provider of considering utilization as a factor" was deleted after the word "neutrality" for accuracy and consistency with section 9; and sections 38 and 39 were added to delete references to statutes being repealed in section 41.

HS	*Joint Favorable Subst. C/R*	APP
APP	*Joint Favorable Subst.*	